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PROGNOSIS FOR PERSONALITY DISORDERS IN THE NAVAL SERVICE.(U)
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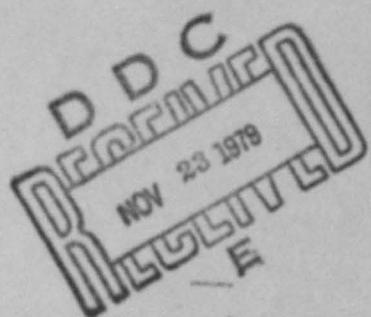
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PROGNOSIS FOR PERSONALITY DISORDERS IN THE NAVAL SERVICE*

J. M. GOFFMAN, PH.D.

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REPORT NO. 75-25



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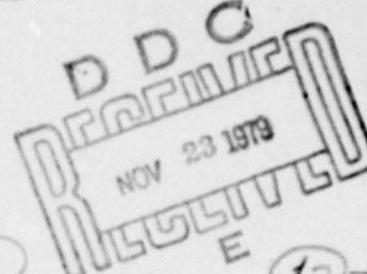
⑥ Prognosis for Personality Disorders
in the Naval Service*

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THIS REPORT IS ABOUT

Personality disorders are a major burden in the Armed Forces and are seen in large numbers in civilian outpatient practice. Prognosis generally has been regarded as poor or uncertain, but specific prognostic indicators have not been evaluated systematically. The present study investigates the prognostic validity of demographic and clinical information in a large sample of Navy personality disorder cases and develops actuarial tables for predicting post-hospital adjustment.

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Prognosis for Personality Disorders
in the Naval Service*

Jerry M. Goffman, Ph.D.

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E. K. Eric Gunderson, Ph.D.

Personality disorders constitute a major problem for the Armed Forces. During a recent period about two-thirds of all psychiatric admissions, three-fourths of all psychiatric discharges from naval service, and one-half of all hospital days for psychiatric cases were attributable to personality disorder cases.¹ Personality disorder patients are seen in civilian practice in large numbers but usually in outpatient rather than inpatient settings. These disorders are characterized by deeply ingrained maladaptive patterns of behavior that are life-long and recognizable in adolescence or earlier.² Prognosis for this type of disorder typically has been regarded as poor, and clinical and predictive studies of such cases in the military service have tended to substantiate this assumption.^{3,4,5,6,7}

Evaluation of personality disorder patients occupies most of the working time of Navy psychiatrists, and these disorders constitute a significant proportion of the adjustment problems seen by the general medical officer. Personality disorders also account for a large proportion of disciplinary and administrative separation actions. Thus, dealing with personality disorders is a major burden for Navy medical and administrative personnel and, eventually, for similar services in the civilian community. Complicating the prob-

lem is the fact that personality disorder subcategories tend to be poorly defined, and diagnosis, prognosis, and treatment outcomes tend to be vague and uncertain.^{8,9} Basically, personality disorders, although heterogeneous in their phenomenological aspects, imply certain defects or disturbances in personality structure and functioning which seriously interfere with successful living. These adjustment problems generally appear to be incompatible with effective military service where standards of conduct tend to be uniform and well-defined, reliability of performance is emphasized, and close interpersonal relationships cannot be avoided.

This report is one of a series addressed to the problems of epidemiology, diagnosis, prognosis, and treatment effectiveness in psychiatric disorders. A previous report considered the meaningfulness and prognostic value of diagnostic subtypes under the general rubric of personality disorder.⁹

The present study investigates factors related to prognosis and seeks to provide useful guidelines for disposition decisions.

Method

Subjects.-- Subjects were 10,526 male, Navy enlisted personnel discharged from Navy medical facilities with diagnoses of Character and Behavior Disorders during Calendar Years 1966-1969. Diagnoses were established with reference to the Department of Defense Disease and Injury Code (DDDIC), July 1963. With adoption of the International Classification of Disease, Eighth Edition by the Armed Forces on January 1, 1970, this general category was designated Personality Disorders. Patients with diagnoses of Alcoholism were omitted from the study. For cases with more than one admission during the four-year period, data from the first admission were utilized, and for cases in which transfers from one hospital to another occurred, data recorded at the last hospital

were used. A major phase of the study involved 3,913 subjects who were returned to full duty after hospitalization. Outcome studies could be conducted only for this portion of the population. The composition of the Return to Duty (RTD) subsample in terms of demographic characteristics is shown in Table 1. The racial distribution for the RTD group was the same as that for the general Navy enlisted population and the average General Classification Test (GCT) score was slightly below that of the Navy generally (53 versus 55).

Data Collection.-- Individual records for all psychiatric hospitalizations in naval service are received at the Bureau of Medicine and Surgery Data Services Center, Bethesda, Maryland. These records are forwarded to the Naval Health Research Center, San Diego, California, where they are extensively edited and maintained in computer files for epidemiological and clinical research. The records contain the following information: age, years of service, pay grade (rank), occupational specialty, sex, race, marital status, duty station, admitting facility, hospital transfers, length of hospitalization, primary and secondary diagnoses, and type of disposition from the hospital. From this information a set of variables was selected to develop predictive equations for post-hospital adjustment.

Criterion data pertaining to success or failure after return to duty were obtained from two sources: inpatient psychiatric files provided rehospitalization data and Bureau of Naval Personnel computer tapes provided information as to date and type of discharge from the service and recommendation for reenlistment. The success or effective performance criterion, then, was based upon completion of at least six months on active duty after hospitali-

ization, and, if separated from service after six months, completion of current enlistment with a favorable discharge and a positive recommendation for reenlistment; rehospitalization for a psychiatric condition or receiving an unfavorable discharge (such as Unsuitability, Unfitness, or Bad Conduct) or a negative recommendation with respect to reenlistment were the bases for classifying the individual a failure.

Procedure.-- The analysis was conducted in four phases. The first phase was concerned with factors affecting decisions to return men to duty. For this part of the study, all men returned to duty were assigned a score of 1 while men not returned to duty were assigned a score of 0. Regression equations to predict restoration to duty were then constructed so that variables related to return to duty could be identified and evaluated for importance. This procedure was followed for the total population and for each of four major naval hospitals individually.

The second phase of the analysis was concerned with prediction of post-hospital adjustment (success) of men returned to duty (RTD). In this phase regression equations were constructed to predict success (1) versus failure (0); this analysis provided an evaluation of factors related to post-hospital outcome and their relative importance for the entire returned to duty population and for the four individual hospitals separately.

The third phase was concerned with estimating the rate of error in the decisions to return men to duty or not, that is, estimating the proportion of men not returned to duty (NRTD) who were good risks.

Finally, in the fourth phase the predictive equation derived in the second phase to predict post-hospitalization success in the validation sample

was applied to a cross-validation sample of personality disorder inpatients discharged from naval medical facilities during Calendar Years 1970-1971.

Results

The total sample was divided into two groups, those returned to duty (RTD) and those not returned to duty (NRTD) from the hospital. Table 1 compares the RTD and NRTD groups on demographic variables for the validation (1966-1969) sample; characteristics of the RTD group only are shown for the 1970-1971 sample. In the 1966-1969 sample the RTD group was older, had longer service, and had achieved higher pay grades on the average than the NRTD group; the RTD group also had shorter hospitalizations than the NRTD group. The 1970-1971 RTD group was slightly younger, less experienced, and had shorter hospitalizations than the 1966-1969 group but had about the same success rate.

Table 2 shows the percentages of patients classified as successful in each diagnostic subtype of the validation sample. Patients in certain subtypes were more likely to be returned to duty than others: Other and Unspecified (Hysterical, Sociopathic), Aggressive, Antisocial/Dyssocial, and Sexual Deviation. These groups tended to have relatively low success rates, however. The lowest return to duty rate was for Enuresis and other symptomatic habits (15%). Schizoid patients also had a low RTD rate (26%).

The analysis to determine selective factors in dispositions from the hospital indicated that age, length of service, pay grade, and days hospitalized were positively correlated with the RTD criterion. Pay grade and hospital days were the most important variables apparently involved in decisions to return men to duty; patients with higher pay grades and shorter hospital-

izations were more likely to be returned to duty.

Post-Hospital Success.-- The success rate for the returned to duty patients was 39% overall. Approximately 26% completed their enlistments and were recommended for reenlistment while 11% continued on active duty status to the end of the follow-up period; 2% received medical discharges unrelated to their psychiatric conditions, and a few cases (less than 1%) died while on active duty. The major type of failure was rehospitalization (29%); 6% were discharged and not recommended for reenlistment at the end of their tours of duty, and 26% were prematurely discharged for administrative reasons.

Four diagnoses accounted for a large proportion of the patients in the return to duty sample. The largest group was diagnosed Passive-Dependent Personality (38.2%), the next largest groups were Emotional Instability (24.0%), Other and Unspecified (Immature, Compulsive) Personality Disorders (13.8%), and Schizoid Personality (10%). Success rates differed for the various diagnostic groups as shown in Table 2. The Passive-Dependent group exhibited the best prognosis with a success rate of approximately 44%. The Other and Unspecified (Immature, Compulsive) and Inadequate Personality categories had success rates of 41%, while the Antisocial/Dyssocial category had the poorest prognosis with a 10% success rate.

Regression Equations for Predicting Post-Hospital Success.-- The regression equation performed on the RHD sample of patients to determine selective factors which predicted post-hospital success yielded a multiple correlation of .28. The nine significant variables, their correlations with the criterion, and the regression weights are shown in Table 3. The most important contributors to the equation were job specialty and pay grade. Job specialty was a

complex variable reflecting both occupational differences and pay grade; that is, certain of the occupational groups were composed predominantly of men in low pay grades. Pay grade as a single variable had the highest correlation with the success criterion. Three variables reflecting interaction effects -- job specialty and pay grade, pay grade and length of service, and days hospitalized and length of service -- made unique contributions to the prediction of the criterion. Duty station (submarines and training assignments tended to be favorable) and race (non-Caucasian tended to be unfavorable) also contributed significantly. The multiple correlation achieved with the success criterion for the total personality disorder sample was modest ($R = .28$), and the cross-validation coefficient obtained when the equation derived for the 1966-1969 sample was applied to the 1970-1971 sample was .20.

Separate regression equations also were derived for the four major hospitals. Patient characteristics and success rates for the individual hospitals are shown in Table 4. Hospitals B and D had higher success rates than Hospitals A and C. Hospital A tended to treat older, more experienced men than the other hospitals. The prediction equations derived for the separate hospitals all achieved much higher multiple correlations with the success criterion than the .28 obtained for the total personality disorder population (A - .40, B - .45, C - .39, and D - .44). Three variables -- pay grade, diagnosis, and marital status -- were consistent predictors of post-hospital adjustment at all four hospitals but other variables tended to be unique for each hospital. The dramatic improvement in predictability achieved when hospitals were considered individually suggested that specific factors were affecting evaluation and treatment practices at the various hospitals.

The next analysis estimated the gain in effective manpower that might be

achieved if the equation derived to predict success among men returned to duty was applied to the sample not returned to duty. The distribution of success scores computed in this way indicated that only 12% of the NRTD patients would have had more than a 50% probability of performing satisfactorily. Therefore, the potential for returning more personality disorder patients to duty successfully appeared to be very limited in the total population. When the same procedure was applied to NRTD patient cohorts at individual hospitals, the following percentages of NRTD patients were estimated to have more than a 50% probability of success if returned to duty; Hospital A - 7%; Hospital B - 19%; Hospital C - 14%, and Hospital D - 28%. It is noted that the hospitals with higher success rates, Hospitals B and D, were the hospitals with the best potential for returning more patients to duty successfully.

The equations obtained in the above analyses do not provide clinicians with practical guidelines for deriving valid dispositions. A more practical approach would be to use readily available information which can be easily quantified. One simple solution would be to use pay grade alone because it accounts for more than 50% of the explainable variance when predicting post-hospital adjustment and was also of primary importance in determining dispositions by clinicians. Additional refinement in prediction could be based upon rates of success for patients using the pay grade variable modified by the inclusion of diagnostic subtype. As indicated in Table 5, men in pay grades E-4 or higher who have been diagnosed Immature Personality can be expected to perform with moderate to high success rates whereas for the Pathological Personality type high success rates can be expected only for pay grades E-6 or higher. Table 6 shows the relationship between pay grade and

success as modified by the introduction of marital status and indicates other discriminations which can be made. For example, from the Table it can be seen that below pay grades E-4, whether single or married, less than 40% of the cases would be expected to perform successfully while men in pay grades E-4 and above who are married have an expected success rate of 54% or higher.

Discussion

The goal of this study was to identify factors predictive of post-hospital adjustment for Personality Disorder patients and to provide valid indicators and practical guidelines for disposition decisions.

A substantial proportion (37%) of the personality disorder population was returned to duty in the present study. The large number of failures after return to duty suggests that better methods of evaluation and selection are needed. Naval experience and length of hospitalization appear to be the most important factors contributing to selection of those returned to duty and both of these indicators have some validity. The salience of these variables probably reflects the clinician's judgment as to the importance of severity of illness, indicated by length of hospitalization, and previous successful work record, indicated by pay grade achieved, as indicators of future adjustment and performance.

This study confirmed the prognostic importance of a number of variables reported in previous studies,¹¹ such as pay grade, length of service, marital status, and days hospitalized, and revealed the prognostic significance of diagnostic subtype. Pay grade was the best indicator of future success for individual hospitals as well as the total population, suggesting general

validity for this variable.

The results of this study indicate that more accurate decisions regarding prognosis could be achieved using pay grade in combination with diagnosis and marital status. Table 7 provides a concise summary of these relationships and provides a simple method of assessing prognosis for specific subgroups by establishing probabilities for post-hospital success.

Table 7 represents prognostic information derived for the total RTD patient sample. Differences in predictability noted among individual hospitals suggested that more valid decisions might be achieved by developing actuarial tables for major hospitals separately.

Personality disorder patients as a total group have poor prognoses for successful adjustment after hospitalization in naval service. Certain subgroups of patients defined by this study have reasonably good prognoses, however, and using the three items of information (diagnosis, pay grade, and marital status) as shown in Table 7, clinicians and administrators could readily identify these cases. An effective procedure might be to assign "odds-for-success" scores based upon the simple combinations of categorical variables shown in Table 7 and then to use other clinical information developed in the psychiatric evaluation to adjust this probability estimate upward or downward. One recent study¹⁰ indicated that simple prognostic ratings given by psychiatrists at the time of discharge from a major naval hospital predicted post-hospital outcome for personality disorders fairly well, and another study¹¹ demonstrated the prognostic value of other service history variables, such as service schools completed and recent disciplinary offenses. Thus, psychological or psychiatric evaluation might reveal a number of positive indicators for a married Petty Officer Third Class (E-4) with a diagnosis of

Schizoid (Pathological) Personality who would score only 41% in the "odds-for-success" actuarial table, and the clinician, considering additional positive clinical evidence, might adjust the odds to 50% or 60% and recommend return to duty for this sailor. The objective here would be to reach a deliberate and well-informed decision based upon valid actuarial indicators of success and appropriate clinical examination and psychological evaluation. Follow-up of a series of cases would provide feedback with respect to the validity of additional clinical variables and could provide a basis for further improvement in disposition decisions.

In general, the findings of this study demonstrated that actuarial methods can aid clinicians responsible for prognostic recommendations by providing valid weightings of demographic, service history, and clinical information found predictive of post-hospital adjustment. Future studies are needed to evaluate how differences among hospitals in diagnostic and treatment policies and practices affect post-hospital success rates.

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Footnotes

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Table 1
Demographic and Clinical Characteristics of
Personality Disorder Subgroups

<u>Variable</u>	<u>1966-1969</u>		<u>1970-1971</u>	
	<u>RTD^a</u>	<u>NRTD^a</u>	<u>RTD</u>	<u>S.D.</u>
Age	21.95	4.67	20.52	2.58
Length of service	3.36	4.31	1.88	2.14
Pay grade	3.09	1.32	2.66	.95
GCT	53.34	9.85	53.24	10.00
Days hospitalized	24.60	37.12	36.18	33.16
% Success	39	-	-	40
Number of cases	3913	-	6613	1335

^aRTD - Returned to duty; NRTD - Not returned to duty.

Table 2

Return to Duty and Success Rates for
Personality Disorder Subtypes

<u>Diagnostic Subtype</u>	<u>Number of Cases</u>	<u>% RTD</u>	<u>% Success</u>
Pathological Personality:^a			
Schizoid	1532	26	36
Paranoid	143	37	28
Inadequate	437	31	41
Antisocial/Dyssocial	138	44	10
Sexual Deviation	117	43	34
Other and Unspecified (Hysterical, Sociopathic)	247	54	30
Immature Personality:^b			
Emotional Instability	2681	35	36
Passive Dependency (Passive Dependent, Passive Aggressive)	3663	41	44
Aggressive	87	51	36
Enuresis, Other Symptomatic Habits (Somnambulism)	127	16	45
Other and Unspecified (Compulsive, Immature)	1284	42	41

^aThe Cyclothymic subtype was omitted because of the small number of cases (N = 23).

^bThe Drug Addiction subtype was omitted because of the small number of cases (N = 47).

Table 3
Variables and Regression Weights for
Predicting Post-Hospital Success

<u>Variable</u>	<u>r^a</u>	<u>Beta Weight^b</u>
Job specialty	.20	.06
Pay grade/length of service ^c	.19	.11
Diagnosis	.09	.05
Duty station	.09	.07
Age	.14	.05
Job specialty/pay grade ^c	.13	.06
Days hospitalized/length of service ^c	.09	.05
Race (Caucasian)	.08	.04
Pay grade	.21	.06

R = .28, N = 3913

^aCorrelation with success criterion

^bAll variables contributed significantly ($p < .05$) to the prediction of success.

^cCombinations of categories for two variables linearized with respect to the criterion.

Table 4

Patient Characteristics and Success Rates for
Personality Disorders by Major Naval Hospital

<u>Variable</u>	<u>Hospital A</u>		<u>Hospital B</u>		<u>Hospital C</u>		<u>Hospital D</u>	
	<u>Mean</u>	<u>S.D.</u>	<u>Mean</u>	<u>S.D.</u>	<u>Mean</u>	<u>S.D.</u>	<u>Mean</u>	<u>S.D.</u>
Age	23.4	6.4	21.7	3.8	21.8	4.4	21.6	4.5
Length of Service	4.8	5.5	3.3	3.5	3.2	4.5	3.3	4.2
Pay Grade	3.4	1.5	3.2	1.2	2.9	1.3	3.1	1.3
GCT	54.0	9.7	54.6	9.4	53.3	10.0	52.0	9.8
Days Hospitalized	49.0	61.5	31.3	35.2	20.4	31.3	22.5	30.2
% RTD	36.2		30.1		41.4		24.6	
% Success	36.0		42.8		37.6		42.7	
Number of Cases	406		406		293		451	

Table 5

Post-Hospital Success Rates for Personality Disorders
by Pay Grade and Diagnostic Subtype

		Pathological Personality												Immature Personality									
		Total Sample				Schizoid				Inadeq.				Other ^a				Emot. Instab.		Pass-Dep.		Other ^b	
Pay Grade	% Success	N	% Suc	N	% Suc	N	% Suc	N	% Suc	N	% Suc	N	% Suc	N	% Suc	N	% Suc	N	% Suc	N	% Suc		
E-1, E-2	28	145	22	57	39	56	23	369	25	490	31	231	33	85	16								
E-3	40	150	41	55	44	46	30	352	38	510	42	184	42	93	27								
E-4	49	44	45	10	30	15	47	119	49	199	53	65	52	35	34								
E-5	53	37	46	12	42	13	38	67	51	154	63	33	45	35	37								
E-6 through E-9	62	16	61	1	-	3	-	30	60	150	61	24	79	19	52								

^aOther and Unspecified (Hysterical, Sociopathic)

^bOther and Unspecified (Immature, Compulsive)

Table 6

**Post-Hospital Success Rates for Personality Disorders
by Pay Grade and Marital Status**

<u>Pay Grade</u>	<u>Total Sample</u>	<u>Married</u>		<u>Single/Other</u>	
	<u>% Success</u>	<u>Number of Cases</u>	<u>% Success</u>	<u>Number of Cases</u>	<u>% Success</u>
E-1, E-2	28	179	24	1243	28
E-3	40	305	41	1077	40
E-4	49	191	54	293	46
E-5	53	204	56	139	47
E-6 through E-9	62	188	65	53	53

Table 7

Success Rates for Combinations of Diagnostic Subtype,
Pay Grade, and Marital Status Categories

<u>Diagnostic Type</u>	<u>Pay Grade</u>	<u>Marital Status</u>	<u>Number of Cases</u>	<u>% Success</u>
Pathological Personality ^a	E-3 or less	Single,	531	30.1
		Other		
		Married	87	28.7
	E-4	Single,	64	40.6
		Other		
		Married	32	40.6
Immature Personality ^b	E-5 or greater	Single,	57	36.8
		Other		
		Married	65	53.8
	E-3 or less	Single,	1566	35.2
		Other		
		Married	354	36.4
	E-4	Single,	207	47.3
		Other		
		Married	143	56.6
	E-5 or greater	Single,	123	52.0
		Other		
		Married	297	63.3

^aIncludes Schizoid Type, Inadequate Personality, Paranoid, Antisocial/Dysocial, Sexual Deviation, and Other and Unspecified (Hysterical, Sociopathic).

^bIncludes Emotional Instability Reaction, Passive Dependent Personality, Aggressive, Symptomatic Habits, and Other and Unspecified (Compulsive, Immature).

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